Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008899	A. BUILDING _____ B. WING _____	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00084717 Unsubstantiated: No deficiencies cited. Date: 8/11/11 Facility Number: 008899 Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor Select Specialty Hospital d.b.a. Kindred Hospital of Northwest Indiana, is in compliance with 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-8, Physical plant, and 410 IAC 15-1.6-7, Respiratory care services, Indiana Hospital Licensure Rules. QA: claughlin 08/17/11	S 000		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE